State of California
Health and Human Services Agency
Department of Managed Health Care
Fraud Complaint Form
DMHC 20-220 New: 03/14

Fraud Complaint Form For Reports of Scams in Selling Health Insurance

Complaint Detail Information:

1) What did the company offer you:

_____

_____

2) Did you receive what was offered: ☐ Yes ☐ No

3) Do you believe the company made inaccurate statements: ☐ Yes ☐ No

4) What statements do you believe were inaccurate:

_____

_____

5) Did you pay the company: ☐ Yes ☐ No

If so, how much did you pay: _____

What method of payment was used: _____

6) When did the company first contact you (mm/dd/yyyy): _____

7) What was your initial response:

_____

_____

8) How were you contacted:

☐ Phone
☐ E-mail
☐ At Home
☐ At Doctor's Office, Pharmacy, or Hospital
☐ Advertising - please describe content and location
☐ Other – please explain

_____

_____

9) Did you sign any documents from the company: ☐ Yes ☐ No

10) Did you provide the company with any personal or financial information: ☐ Yes ☐ No

11) Please list any other agencies or entities you contacted for help:

_____

_____

12) What do you want, need, or expect in order to resolve your complaint:

_____

_____

Additional Information

Please add any additional information that is important about your experience, including information about the company, what was offered to you, and whether you received what you were offered.

Consumer Information

Please provide your contact information so that we can contact you for further information about your complaint, if necessary.

First Name _____ Last Name _____

Mailing Address _____

City _____ State _____ Zip _____

Daytime Phone # _____ Evening Phone # _____

E-mail _____

Company Information

Please report any information you have about the company.

Company Name _____

Mailing Address _____

City _____ State _____ Zip _____

Phone # _____ E-mail _____

Website _____

Company Representative Name _____

Company Representative Title or Position _____

Phone # _____ E-mail _____

How did the representative describe his/her affiliation (e.g. Plan, Covered California, Government Program, etc.): _____

13) Do you have any documents from the company: ☐ Yes ☐ No

If you have any documents relevant to your case that you would like to provide, please include a copy of them with your submission.

I am asking the Department of Managed Health Care (DMHC) to assist me with my complaint. I understand that the DMHC will safeguard my personal information. If my complaint falls within DMHC's jurisdiction, DMHC may further investigate it and may contact me. If appropriate, DMHC may refer my complaint to Covered California, the Department of Insurance, or another agency for further review.

Signature:_____ Date:_____

Instructions:

To submit a Fraud Complaint Form by mail or fax:

1. Complete and sign the form. If you need additional space to complete your answer, please attach a separate page.
2. Attach copies of letters or other documents you believe may be relevant to your complaint. Please send copies of documents, not originals. The Help Center cannot return any documents.
3. Fax or mail the form and copies of any supporting documents to:

   Help Center
   Department of Managed Health Care
   980 9th Street, Suite 500
   Sacramento, CA 95814-2725

   FAX: 916-255-5241

If you have questions about the fraud complaint form, please call the Help Center toll-free at 1-888-466-2219 or (TDD) 1-877-688-9891.